Reviewer’s report

Title: Clinical ethics dilemmas in a low-income setting - A national survey among physicians in Ethiopia

Version: 0 Date: 17 Apr 2019

Reviewer: Marcel Mertz

Reviewer's report:

GENERAL

I thank for the opportunity to review this interesting paper. Widening our view regarding the occurrence and perception of ethical dilemmas/conflicts etc. is important in order to avoid setting priorities that are biased by the perspectives of high-income countries. This could be especially important for global health ethics issues and the development of ethics guidelines from international organizations (such as the WHO).

I do not have strong concerns regarding the paper, which is, in general, well written and relevant. Still, I think some points - two more major ones, several more minor ones - should be addressed to further improve the paper.

MAJOR CONCERNS

Comment 1: One major concern I would like to raise is the definition used for "ethical dilemma". Philosophically, an ethical dilemma is a situation where two actions are possible, but both are, actually, ethically bad (there is no really ethical solution possible), or (using another description) where two moral obligations would lead to contradicting actions (not both are possible at the same time). In my experience, in medical ethics, often a broader understanding is used. "Dilemma" then includes situations where there are conflicts between e.g. mid-level principles or values, and one has to balance and weigh them in order to make a decision. The difference to the more strict definition is that the latter allows for ethically defendable solutions ("better" vs. "worse" actions).

I assume that also in the paper, a broader understanding is used, as e.g. is illustrated by not always using the same term. So, for example, on p. 7, lines 47-48, the question used in the questionnaire asked for "ethically challenging situations". However, an ethically challenging situation could also be a situation where, in principle, there could be a rather clear ethical solution (that is better than the alternatives), but the person just does not know about it (the lack of knowledge leads to experiencing the situation as "challenging"). On p. 8, lines 19-23,
"dilemmas" as well as "challenges" are used (apparently interchangeably). On p. 13, lines 2-13, situations are labelled as "dilemmas" where specific actions are not possible due to e.g. "limited staff" or "lack of hospital beds" etc. These are rather deficiencies or "bad states of affair" where it is, in general, not controversial that they are ethically problematic (or lead to ethically unsatisfactory actions). There is no conflict between possible actions or principles in such situations that makes balancing/weighing necessary, as the ethically better/best action is not available right from the start. Of course, it is psychologically challenging to be confronted with such situations (see also the moral distress debate that the authors also mention in their paper). However, one could argue that these are not "ethical dilemmas" understood as "conflicts" where physicians have to make a decision for/against a certain course of action (as the course of action is "imposed" on them due to the lack of alternatives). Finally, on p. 30, lines 7-10, it is talked about "ethical uncertainty, ethical conflict and insufficient resources" - is this all to be subsumed under the term "dilemma"?

For addressing this first major concern, I do not propose that the authors have to completely change the terms, or have to use the more strict definition of dilemma. However, the paper should definitely state how "ethical dilemma" is understood (and/or acknowledge some ambiguity in its use, e.g. being more open for the respondents of the questionnaire). Also, the consistency of the terms or the understanding used should be increased throughout the paper (is "ethical challenging situation" or "ethical uncertainty" always the same as "dilemma"? If not, please make that clearer etc.).

Comment 2: I wondered whether some of the response options used ("often/sometimes/rarely/never or not applicable", p. 8, lines 24-25) were, in the end, not too subjective. Or were there any further specifications regarding what "often" could mean (e.g. "every day")? If yes, please add this information.

If not, it seems to have been completely left to the individual perception what e.g. "often" means compared to "rarely"; physician A could have rated the same frequency of dilemmas occurring as "often", while physician B could have rated it as "sometimes" (or even "rarely", as she/he had another impression of what "often" means). This makes assertions about the (objective) frequency of the occurrence of dilemmas (see also abstract of the paper) much more difficult.

At least, then, this seems to me to be an important further limitation of the study that is not addressed in the limitations section, and that is also insufficiently reflected in sentences such as "[...] show that respondents frequently encountered dilemmas […]" (p. 25, lines 4-8) or "[...] describe this to be an everyday occurrence" (p. 27, lines 27-31), which sound more objective than what the method used by survey could ensure. So, this limitation should be added and better reflected in the paper (discussion and conclusions).
Comment 3: p. 6, lines 9-11, "Numerous empirical studies describe [...]" - Please add some examples of these studies as references.

Comment 4: p. 7, "Method": Of course it is fully legitimate to refer to the other paper for details about the survey method. As this paper was published 2015, however, it would still be at least helpful if the original time frame of the survey (when was the survey conducted?) is added as information to the current text.

Comment 5: p. 8, lines 32-37, "The other question used [...]" - Were the participants provided with a definition of "ethical dilemma", or were the participants free to include everything they themselves understood as "dilemma" (= subjective interpretation), even if the situations reported were more deficiencies/"bad states of affair" where it is obvious that they are ethically problematic? (See also remarks in comment 1 above).

Comment 6: p. 25, lines 14-15, "[…] we have few data from other low-income countries […]" - If there is "few data" (and not "no data"), then, please add at least one or two publications reporting this data as references.

Comment 7: p. 27, concept of "moral workload": Though I personally like this new concept, I have two problems with its presentation in the paper. First, if the aim of the concept is "to define the extent and frequency of ethical challenging situation", and could also be used as a "possible metric", the survey method used might not be a good example for the concept's use (at least when the concern mentioned in comment 2 is true, i.e. that the response options were very subjectively defined, as the (external) validity of assertions regarding "frequency" based on the study is problematic). Second, introducing a new concept (with explanations etc.) in the discussion section, as part of the main text, is disrupting the discussion of the results. Would it be possible introducing the concept earlier (background, methods)? Or is it possible to insert further explanations of the concept in an endnote (so that they are not disrupting the discussion of the results)?

Comment 8: p. 28, lines 42f, "[…] cultural, religious or socio-economic background […]" - The examples mentioned for cultural, religious and socio-economic background are mainly directed to the relation of the patient to the family (which culturally might make sense, but then, it would be helpful to add a sentence that these issues most often occur regarding the ways patients and their families interact with each other, or make decisions etc.). Are there also other examples that could be mentioned, esp. for different cultural backgrounds?

Comment 9: p. 29, lines 47-48, "[…] from previous studies […]" - Which studies are meant? Please add some references.
Comment 10: p. 30, lines 5f, "What our study highlights, is the need for ethics training, support systems […]" - This seems to presume that with this training etc., there will be necessarily "better" ethical decision-making, not just less moral distress, or an increase in subjective well-being of the decision-makers. However, a known problem of, for example, the evaluation of clinical ethics support services (CESS) is exactly how one could determine that the ethical decision-making is "better" afterwards (and not just leads to more satisfaction of the decision-makers when making a decision, which could, in principle, also be ethically worse than an alternative). Thus, it might be sensible to add a sentence what exactly should be (or might be) improved by such training and support.

Comment 11: table 1 - As the "number who answered this question" vary, it would be helpful for interpreting the table if not only relative frequency is mentioned (where applicable), but additionally, absolute numbers are given. For "average work hour …" and "average number of patients", adding the range would also be helpful.

Comment 12: table 2 - Some dilemmas listed in the table are a bit problematic: a) The specific dilemma "Limitation of resources required you to make a difficult choice" seems to be very broad, so that it could also subsume other dilemmas in the table (e.g. "There was significant disagreement among health care personnel on continuing treatment if the patient due to lack of resources"). b) The specific dilemma "You worried if you were helping or hurting the patient with the interventions" does not seem to be a dilemma or conflict, but insecurity or uncertainty (but see also remarks about the terms and definitions used in comment 1). c) Specific dilemma "A patient's cultural or religious views conflicted with your proposed course of treatment" is subsumed under the category "Disagreement with/within family", which does not seem to be plausible at the moment (see also comment 8). Is there a possibility to rearrange/slightly revise the three dilemmas or their respective categories?

Comment 13: figure 1 - In the figure, there are 24 items mentioned, in table 2, only 22 items (e.g. "You were asked to help a patient to have a comfortable death or to take their own life" is not included in table 2). Is this by purpose, and if yes, what is the rationale for it?

SUGGESTIONS

Comment 14: Often, there is a blank character missing before the reference (e.g. p. 6, lines 52-53, "[…] is one of the strategies(10)"). Maybe correct this in the revised version?

Comment 15: p. 9, lines 26-27, "Physicians with less than one-year of service […]" - Maybe change to "Questionnaires of physicians with less than one-year of service […]" or something similar?
Comment 16: p. 11, lines 30-31 - There seems to be a comma instead of a full stop after "Limitation of resources is the major challenge".

Comment 17: p. 29, lines 55-56, "[…] generalizable to other low-income settings [...]" - Maybe "generalizable" is too strong, considering the limitations of the study. Better use a weaker term?

Comment 18: p. 31, lines 22-23, "Implications of this study" - If I remember the author guidelines of BMC Med Ethics correctly, I think this section has be called "Conclusions", and has, as a heading, be on a higher level (as e.g. "Results").

Comment 19: table 2 - "The preferred course of treatment was not pursued because of a patient's ability to pay"; should that not be "inability"?

Are the methods appropriate and well described?
If not, please specify what is required in your comments to the authors.

Yes

Does the work include the necessary controls?
If not, please specify which controls are required in your comments to the authors.

Unable to assess

Are the conclusions drawn adequately supported by the data shown?
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